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ABSTRACT

Although plentiful information is available about the long-term treatment of sexual abuse survivors, a framework for the short-term treatment of this population is lacking in the literature. A preliminary model of screening and goal-setting in short-term therapy for survivors, to be used at university and college counseling centers, is presented in this paper. The model integrates short-term therapy models (time-limited therapy) with trauma-based theory and therapy. It emphasizes the importance of screening for short-term therapy and presents some questions that should be answered upon intake. Goal setting and therapy as an episodic endeavor--where clients frame therapy as time-limited "chunks" of work--are detailed. The bulk of the paper discusses the applicability of phasic models, and it offers three approaches to phasic work, along with strategies in using these models. Attention is given to considerations in evaluating the appropriateness of goals and how to determine an appropriate "chunk" of trauma work for short-term therapy. Other concerns that are covered include contracting, repressed memories, and support systems. Limitations, research needs, and future expansion of the model are discussed. (Author/RJM)

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A Model of Screening and Goal-Setting in Short-Term Counseling with Sexual Abuse Survivors

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Abstract

Although plentiful information is available about long-term treatment of sexual abuse survivors, a framework for the short-term treatment of this population is lacking in the literature. A preliminary model of screening and goal-setting in short-term therapy for survivors, to be used at university and college counseling centers, is proposed. The model integrates short-term therapy models (Budman & Gurman, 1988; Horowitz, 1991; Mann, 1973) with trauma-based theory and therapy (Briere, 1989, 1992, 1996; Courtois, 1988; Herman, 1992; Williams, 1994). Primary elements of a theoretical model are screening clients, selecting and setting appropriate goals, and making needed modifications for the short-term treatment of adult survivors. Limitations, research needs, and future expansion of the model are discussed.

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A Model of Screening and Goal-Setting in Short-Term Counseling with Sexual Abuse Survivors

One of the problems psychologists at college and university counseling centers face is how to serve clients with long-term problems, given that the majority of these agencies are now confined to providing short-term services. Do we assign all of these clients to long-term individual counseling and ignore agency restrictions and waiting lists? Do we see clients individually for a short period of time, then refer them out to other agencies despite the difficulty clients may have establishing trust and rapport with a new therapist? Do we refer all long-term clients out of the agency to pay for services, although they have the same money problems as other students granted counseling center services? How do we best meet the needs of this challenging population in an ethical and sensitive manner?

Survivors of sexual trauma, including child sexual abuse (CSA), challenge counseling center staff to examine these issues. Sexual abuse histories are not uncommon in the college population seeking services. In a sample taken at a university counseling center, the incidence of reported sexual abuse at intake was 16.7% (Braver, Bumberry, Green, & Rawson, 1992). In a second study targeting minority students, sexual abuse was the sixth most common presenting issue at counseling centers, reported by over 20% of these clients at intake (Constantine, Chen, & Ceesay, 1997). Given that many clients with sexual abuse histories do not reveal this information at intake (Courtois, 1988), such figures are is likely to underrepresent the number of students with such concerns, suggesting that students with sexual abuse histories represent a small but significant percent of counseling center clientele. Furthermore, the disclosure of sexual abuse after therapy has commenced complicates the time issue, and makes referral problematic.

Theoretical background

Models of trauma therapy. Treatment planning for sexually abused clients seeking services in short-term settings is difficult given the available models of sexual abuse therapy. Issues resulting from sexual abuse are commonly chronic, and when possible, long-term therapy is usually recommended. The literature is replete with texts and articles describing elegant and useful models of long-term therapy with survivors of child sexual abuse (i.e., Briere, 1989, 1992, 1996; Courtois, 1988; Davies

& Frawley, 1994; Herman, 1992; Kirschner, Kirschner, & Rappaport, 1993; McCann & Pearlman, 1990; Walker, 1994; Wells, Glickauf-Hughes, & Beaudoin, 1995; Williams & Sommer, 1994). Such resources are invaluable, coupling theoretical understanding with detailed discussion of technique. However, in each of these cases, the therapy model is long-term. With few exceptions, counseling center staff rarely have the luxury of contracting with clients for long-term therapy.

Models of time-limited therapy. The short-term therapy literature is similarly extensive, but generally does not target the special needs of sexual abuse survivors. Of the few models that directly address psychological trauma, one model for treating Post-Traumatic Stress Disorder (Horowitz, 1991) expressly screens out survivors of any type of prolonged, complex trauma, particularly those with chronic aftereffects. Rothbaum and Foa (1996) report a nine-session biweekly cognitive-behavioral treatment for Post-Traumatic Stress Disorder (PTSD), but apply this model to apparently single incident adult assault survivors. A third model of short-term therapy targets CSA survivors specifically (Kirschner & Kirschner, 1995), but its time frame of 20 sessions over 40 weeks is significantly longer than the session limits currently adopted by most counseling centers. Proponents of Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995) have claimed impressive success in very rapid treatment, but the research has been inconclusive in supporting such claims (DeBell & Jones, 1997; Lohr et al., 1992; Rothbaum & Foa, 1996). Other alternative therapies (e.g., Thought Field Therapy; see Gallo, 1997, LeShan, 1997, and Speckhard, 1997, for discussion), less well researched than EMDR, are also available, but the training for such approaches is commonly prohibitively expensive for counseling center personnel.

General approaches to short-term psychotherapy are also available. However, for survivors of sexual trauma, general approaches alone are simply not adequate. Specific attention to abuse-related themes, such as memory, suggestibility, and dissociation, is also necessary (Enns et al., 1997).

Rationale. Despite the difficulties inherent in modifying long-term approaches within short-term settings, in college counseling centers we are often called upon to do exactly that. The academic calendar disrupts therapy even in agencies allowing long-term work. Despite the myriad of long-term approaches to the treatment of sexual

abuse survivors, a framework for short-term treatment is lacking in the literature. Given that counseling centers represent a small portion of mental health agencies emphasizing short-term treatment, the development of such a framework is sorely needed. Thus, a model of selecting clients, setting appropriate goals, and conducting a course of short-term therapy is both timely and needed--for use both in counseling centers and other short-term therapy settings.

While a full discussion of all aspects of short-term therapy is beyond the scope of this paper, a model focusing on several key elements will be discussed. The model integrates short-term therapy models (Budman & Gurman, 1988; Horowitz, 1991; Mann, 1973) with trauma-based theory and therapy (Briere, 1989, 1992, 1996; Courtois, 1988; Herman, 1992; Williams, 1994). Primary elements of the model discussed here are screening clients, selecting appropriate goals, and making the special modifications needed for short-term therapy with adult survivors.

Screening

Selection of appropriate clients is crucial in any intensive form of short-term therapy (Mann, 1973; Strupp & Binder, 1984). Because short-term treatment of CSA survivors is frequently contraindicated (Williams, Sommer, Stamm, & Harris, 1994), careful screening is particularly important. Client welfare must be the first priority in assessing appropriateness for short-term treatment, and the following issues may be considered prior to contracting for short-term work. First, how prolonged and extensive is the trauma history? Clients with a history of extensive abuse from multiple perpetrators may be best served in a long-term treatment setting. Second, what is the client's psychosocial history other than abuse? Clients who have had at least one secure bond in their early lives are generally able to make better use of short-term therapy than clients with more profound isolation in their early lives (Mann, 1973). Third, what is the client's overall level of functioning? Clients with profound disturbances in their day-to-day functioning may not be able to make adequate progress in a short-term time frame. Fourth, what is the quality and stability of the client's social support system? Clients with stable external support are more likely to be able to make change in time-limited therapy, although developing a social support network could be considered a legitimate short-term goal. Fifth, has the client received treatment in the past for trauma-related issues? What degree of resolution of these

issues has the client obtained, regardless of past therapy? Clients at the very beginning of trauma work are likely to have greater need for long-term work than clients with considerable resolution. Sixth, has the client received short-term therapy in the past, and if so, with what success? Last--but perhaps most important--what are the client's goals? Even clients with extensive abuse histories may be seen for the purposes of stabilization, but clients with more extensive goals may best be served by referral to long-term services.

In accordance with the collaborative relationship recommended for therapy with survivors (Briere, 1989; Courtois, 1988; Enns, McNeilly, Corkery, & Gilbert, 1995; Phelps, Friedlander, & Enns, 1997; Williams, Sommer, Stamm, & Harris, 1994), the short-term framework should be discussed with clients. The advantages and limitations of short-term work, alternative forms of treatment, and referral sources may be reviewed. Clients are then prepared to make informed choices about whether to engage in this approach, and if so, what they are prepared to share. This process serves the dual purpose of treating abused clients with respect, and empowering clients to make decisions relevant to their lives.

Goal setting

Assuming that a course of short-term therapy has been deemed appropriate for the client, the next challenge the therapist faces is setting appropriate goals. Obviously, the goals in short-term therapy will be more circumscribed than the goals for time-unlimited therapy. Survivors just beginning the recovery process are not likely to work through the entire experience in one course of short-term counseling, even a focused and well-planned therapy.

Therapy as episodic. Conceptualizing counseling as episodic treatment the client revisits as needed, rather than one lengthy course of therapy (Budman & Gurman, 1988), is particularly useful in this regard. Framing therapy to clients in terms of time-limited "chunks" of work can have the benefit of providing them with a sense of increased self-efficacy. If the therapist communicates a genuine belief that a client can take a break from therapy, that client is more likely to believe that he or she can tolerate this as well. This framework also facilitates the therapist's ability to think in terms of defined and restricted goals, and to help the client select more limited goals than would be chosen if time were not a factor. This perspective on therapy may be

shared with clients, who are less likely to view a later return to therapy as a failure if they have been previously assured that this is typical. Obtaining prior treatment records, in addition to obtaining the client's perspective on the past work and completing a sound clinical interview, may assist a new therapist in the assessment of what work the client has already done and what still needs completion.

The applicability of phasic models. Given that phase-oriented therapy is recommended for abuse survivors (Courtois, 1995; Herman, 1992; Horowitz, 1991; van der Kolk, McFarlane, & van der Hart, 1996), a phasic perspective is useful in helping the therapist achieve the difficult task of determining appropriate treatment goals. Three approaches to phasic work are particularly instructive in this regard. These approaches are considered in order of specificity with regard to treatment planning. The first approach, studied by Koraleski and Larson (1997), applies the transtheoretical model of Prochaska, DiClement, and Norcross (1992) (originally developed for use in smoking cessation treatment but later applied to other forms of therapy) to psychotherapy with CSA survivors. The model describes general stages of change in which the client moves from precontemplation to contemplation of a problem, to preparation for change, to action, and finally to maintenance. It was hypothesized that different client behaviors and treatment techniques would be useful to clients at different stages of change. However, this was only partially borne out by the study. Koraleski and Larson found that clients used behavioral processes more at the action stage than at earlier stages, but did not find any difference across stages in the use of experiential processes (e.g., cognitive or affective approaches.)

This model may provide some general guidance to those planning short-term treatment for CSA; clients at the action stage of change may benefit from heightened behavioral intervention. However, at this very early stage of investigation, the model provides little in the way of specific guidance for treatment planning. In the treatment of CSA survivors, general strategies are not adequate. Treatment planning specific to abuse dynamics is essential (Courtois, 1988; Williams, 1994).

The second approach, pioneered by Mardi Horowitz, analyzes what phase of post-traumatic symptomatology the survivor is experiencing, and sets immediate goals and treatment interventions accordingly. The guiding assumption of this model is that therapy should desensitize the survivor to the memories. If the survivor is

experiencing the intrusive/repetitive phase of post-traumatic symptomatology, interventions focused on stabilization and soothing are recommended. If the survivor is chiefly experiencing numbing/restrictive symptoms, exposure techniques are advised. It is presumed that varying the approaches by the symptoms will result in consolidation of the self-soothing work along with the memory work. This approach is useful in its recommendation of intervention strategies specifically tailored to trauma survivors, lacking in the Koraleski & Larson treatment.

The third approach to phasic work considers stages of an individual's trauma recovery over time. Herman (1992) reviewed conceptualizations of trauma recovery, and found three stages common to the different formulations. The stages of trauma recovery she described include safety, in which the survivor attends to basic vulnerability issues developed through the trauma; remembrance and mourning, in which memories and their emotional and cognitive consequences are worked through; and reconnection, in which the survivor reorients toward the future and moves on.

While these stages describe a long-term, possibly lifetime course of trauma recovery, defining the survivor's stage of recovery can help the therapist formulate ideas about what approach would be most useful for clients in short-term therapy. Currently, an individual's stage of recovery must be assessed through clinical interview, past treatment records, and the client's self-report. However, researchers are developing a formalized assessment instrument that may make this process more precise in the future (J. L. Herman, personal communication, July 15, 1997).

The therapist may conceptualize the client's stage of trauma resolution as a way of selecting and focusing upon a "chunk" of work, rather than aiming to resolve the client's entire traumatic experience. Table 1 reviews stages of recovery and possible goals for short-term work for clients at each stage. The table illustrates examples of goals a client may choose in short-term therapy. Of course, treatment goals must be individualized according to each client's needs.

Horowitz's (1991) model offers a general strategy for the therapist to utilize in working toward remembrance and mourning goals. Facilitating remembrance when the client is numb, and stabilization when the client is experiencing intrusive memories, helps the client process and work through the memories. The alternation between exposure techniques in the numbing phase of post-traumatic coping, and the

stabilization approach advised for the intrusive/reexperienceing phase, promotes resolution of the traumas and client mastery over symptoms (Courtois, 1995). Such techniques are similar to the exposure models discussed by Rothbaum and Foa (1996).

As a general rule, the more complex the trauma, the more limited the goals of short-term therapy will be. In some cases, an entire phase (such as the safety phase) may be worked through. At other times, a more limited aspect of the client's recovery (such as improving the safety of the living situation) will be selected. After completing short-term treatment, the client may then consolidate progress and return to therapy when ready. Failure to maintain the focus will result in the dilution of the therapeutic work, resulting in a less desirable outcome or the necessity for recontracting.

Considerations in evaluating the appropriateness of goals. What constitutes an appropriate "chunk" of trauma work for short-term therapy? Decisions on this must be made on a case-by-case basis. The following questions may be useful in determining whether a goal is manageable for a specific survivor:

How consistent is the goal with the client's purpose in coming to therapy? How flexible is the client in her goals? Generally speaking, clients seek help because they want to feel and function better. Clients may or may not want long-term consideration of their traumatic experiences, even if the therapist believes this would be beneficial.

What is the client's level of functioning in day-to-day life (school, job, social and/or family life)? Does the client have adequate social support and a safe place to live? Is the client able to self-soothe?

If the client is functioning well, the goal selected may be relatively affective and insight-oriented. The chosen "chunk" of work may be larger.

If the client is functioning poorly, the goal selected is likely to be comparatively more cognitive/behavioral. The chosen "chunk" of work is likely to be relatively limited.

What has the client's previous therapy experience been? What were the goals of the past therapy experience, and how were time limits handled? Were the client's goals met? How were the goals met, or why were they not completed?

How complex and extensive is the trauma history? In cases of long, severe abuse by multiple perpetrators, episodic therapy is more difficult because of the

profound trust issues typical for survivors of such experiences. Even so, small behavioral goals may be chosen for time-limited work, provided that the client agrees to this plan. In such cases, it is particularly important for the therapist not to push the client toward more disclosure than the client may be comfortable with in a short period of time. Appropriate referrals for later long-term work may be made if the client wishes to pursue this.

How will the proposed goal, if achieved, effect the client's life? This may be the most important consideration. In time-limited therapy, improving the symptoms is paramount.

Further considerations. Contracting is important in any form of short-term therapy, but particularly with abuse survivors. The issues of control and choice are fundamental to sensitive work with survivors, and given that time limits are a factor that clients cannot control, they have the right to know, as much as possible, what they can expect. Further, the ability to recontract with a client who recontacts the therapist after a course of therapy is done is arguably a prerequisite for beginning short-term therapy with abuse survivors. Without such flexibility, the feasibility of contracting for short-term work with a CSA survivor should be considered carefully.

Generally speaking, attempts to uncover repressed memories within the short-term context are not recommended (Kirschner & Kirschner, 1995). Even so, it is not uncommon for students leaving home for the first time to recover memories of abuse spontaneously. Distance from the abusive family, the developmental stage of the student, and the newfound independence and self-sufficiency typical of college life may explain this phenomenon. When memories occur within therapy, recontracting is likely to be necessary to help the student achieve his or her own understanding of the images. If this is the first memory of abuse, the student may need referral for long-term therapy.

Clients struggling with abuse issues need great amounts of support, and one barrier to achieving change in a short-term format is supportive others' resistance to change or ignorance about the process of trauma recovery. In such cases, support figures in the client's life, such as partners, roommates, friends, and/or family members, can be brought in for a session or two (Budman & Gurman, 1988; Kirschner & Kirschner, 1995; Williams, 1994). The purpose of such interventions--to increase

understanding of what the survivor is experiencing, to provide guidance in how the support figure can help, and when necessary, to give the supportive other a referral to therapy--should be clarified to both the client and his or her guest in therapy. Attention to risk management issues, including obtaining informed consent from both the partner and the client, establishing clear understanding of where the therapeutic duty is and where it ends, and clarifying dual roles is particularly important from both ethical and risk management perspectives when this is the case (Knapp & VandeCreek, 1996).

Despite all the above attention to technique, it should be remembered that the therapeutic relationship is the most important factor in therapy with CSA survivors (Olio & Cornell, 1993; Phelps, Friedlander, & Enns, 1997). Time limits provide special challenges in establishing a safe, faciliative relationship with survivors (see Williams, 1994, for a discussion of safety in the therapeutic relationship). The same principles for the therapy relationship in long-term therapy--responsivity, activity, affectivity in session that can be titrated when necessary (Olio & Cornell, 1993), and the balance of intense work with heightened awareness of client strengths (Phelps, Friedlander, & Enns, 1997), also apply to short-term work. The importance of maintaining a nonsuggestive stance (Enns et al., 1995; Herman, 1992; Phelps, Friedlander, & Enns, 1997) is the same in short-term therapy as it is in long-term work. However, some differences are noted. In time limited therapy, less specific attention in session to transference is likely to emerge. While the therapist may note transference and use this knowledge to inform the work, time may not allow for both improving current symptoms and working through transference. In such cases, current symptoms are likely to take priority.

As an ethical imperative and a clinically useful technique, the importance of clarifying time limits as early as possible cannot be overstated. As some clients tend to overlook impending termination, reminders of the termination date may also be utilized. This intervention encourages consistent work in therapy by reminding the client that treatment is finite (Mann, 1973).

Limitations of the model

Typical of therapy models in early development, the current approach has many limitations. The model currently emphasizes goal selection and screening. While these factors are critical aspects of short-term therapy the model needs expansion in

other areas such as technique, ethical application, individualized treatment planning, and further integration of theory. Given that stage of recovery is assessed through clinical interview, client self-report, and prior treatment records, the application of the model will be imprecise. Greater precision in the definition and measurement of stages of recovery will allow for more accurate definition of goals and subsequently, treatment planning.

The model is currently untested, and as such, has no empirical support. This is a problem for many if not most trauma-based theories and therapies, most of which are purely theoretical. The trauma literature in general would be strengthened by further studies of the therapy process, such as recent studies by Koraleski and Larson (1997) and Phelps, Friedlander and Enns (1997).

The challenge for agencies

Counseling centers have the unique challenge of reaching out to diverse student groups with complex needs. Counseling centers need not be equipped to meet all mental health needs of every student . However, in an era where privatization has been an increasing concern to counseling center administrators (Drumm & Hurst, 1996), it behooves these agencies to be creative in meeting the needs of as many students as possible. New approaches, such as allowing long-term group service along with short-term individual work, implementing flexible session limits with the possibility of recontracting when necessary, and team or peer supervision of recontracting offer the possibility of meeting the needs of a student group in clear need of services.

Table 1

Possible Short-Term Treatment Goals by Stage of Trauma Recovery

Stage	Description	Possible Goals
I: Safety	focusing upon building safety in the client's physical and emotional life	* increase self-soothing abilities * improve ability to assess and cope with dangerous situations * increase assertiveness * improve sleep disturbances, anxiety attacks, and other physical symptoms * improve ability to define what survivor wants and does not want * increase self-esteem * develop social support network * improve safety of living situation
II: Remembrance and Mourning	working through memories and associated feelings and thoughts	* working through a memory or a set of memories * using exposure techniques to desensitize survivor to memory/memories * expressing grief for experiences * improve ability to tolerate strong affect * increase compassion for self * reduce flashbacks * integrate emotional response to a trauma with the memory * examine impact of abuse on expectations for self and others
III: Reconnection	refocusing on the future; rebuilding identity; reconnecting with outside world	* examining existential questions * building self-esteem * improving sex life * increasing ability to advocate for self * developing a "survivor mission" (Herman, 1992, pp. 207-211) * handling forgiveness issues

Note: goals listed are only suggestions. The list is not meant to be exhaustive.

Stages of recovery from Herman (1992)

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